All PSNC members can attend this meeting and may speak with the permission of the Chairman.

PSNC Service Development Subcommittee Agenda

for the meeting to be held on Tuesday 13th May 2014

at the Oulton Hall, Rothwell Lane, Oulton, Leeds, LS26 8HN

starting at 4pm

Members: Stephen Banks, David Evans, Margaret MacRury, Indrajit Patel, Janice Perkins, Gary Warner (Chairman)

1. Apologies for absence

No apologies for absence have been received at the time of setting the agenda.

2. Minutes

The minutes of the meeting held on 8th January 2014 were shared with the subcommittee and can be downloaded from PSNC's website.

3. Matters arising

4. Work Plan

The 2014 work plan, including progress updates, is set out at **Appendix SDS 02/05/14 (pages 8-13)** for consideration by the subcommittee.

ACTION / RATIFICATION

5. Update on discussions with NHS Employers

The CEO will make introductory comments and shall provide a reminder of the confidentiality requirements applying to negotiations with NHS Employers/NHS England. A verbal update will then be provided.

6. Identifying external barriers to community pharmacy service commissioning and strategies to address these

The SDS work plan includes an action to review the external barriers to commissioning of community pharmacy services that currently exist in the 'new' commissioning environment, in order that PSNC can also consider strategies that can be used to address these blocks to commissioning. Following the debate on evidence base development at the 2013 LPC Conference, another action within the work plan is to develop and consider proposals on how the sector can gather evidence to support service development.

A paper setting out a range of external barriers to local commissioning of community pharmacy services is set out at **Appendix SDS 03/05/14 (pages 14-16)**. It also includes existing PSNC resources that can be used to overcome some of the barriers. The paper also describes approaches to gathering evidence to support service development.

The subcommittee is asked to consider the contents of the paper and to consider the following questions:

1) Are there other external barriers to community pharmacy service commissioning not listed in the paper that should be considered?

2) What else could PSNC provide to LPCs/contractors to support local service commissioning/overcome external barriers to service commissioning? (i.e. further resources/guidance)

3) What else could PSNC do to address external barriers to commissioning? (e.g. lobbying relevant parties on legislative blocks)

4) What other approaches to gathering evidence to support service developments could be taken by PSNC?

REPORT

7. NHS Friends and Family Test (FFT)

The Government has decided that the FFT will be used across all NHS funded services, including in primary care, where GP practices will implement the FFT from December 2014. The target for implementation across all NHS funded services is by the end of March 2015.

PSNC has had initial discussions with NHS England about how the FFT could be incorporated within the CPCF, following discussions on the matter at previous Committee meetings. The approach to the introduction of the FFT to community pharmacy is still being considered by the Patients and Information Directorate, but they have informed PSNC that they will now 'consider what to do about implementation in pharmacies on a slower track'. As a consequence of this the test will not be introduced into community pharmacy by March 2015.

8. Improving Health & Patient Care through Community Pharmacy – a Call to Action

Following discussions on the content of the PSNC response to the CTA at the January and March 2014 meetings, the response set out at **Appendix SDS 05/05/14 (pages 18-30)** was submitted to NHS England.

9. Law Commission

The Law Commission published its Report on Regulation of Health Care Professionals on 2nd April 2014. It had been asked by Government to conduct a review into the regulation of healthcare professionals because the legislation appeared fragmented, inconsistent and poorly understood. In addition, each of the professions makes demands on legislative time in order to continually update and amend the relevant legislation.

The Review also extended to considering the over-arching body – the Professional Standards Authority, which oversees the work of the professional regulators. The outcome was to recommend that there should be a single statute which regulates all of the healthcare professionals. The main objective for each regulator should be to protect, promote and maintain the health, safety and wellbeing of the public and also to promote and maintain public confidence in the profession and to promote and maintain proper professional standards for conduct for individual registrants.

On the regulation of pharmacy premises, it was recommended that the draft Bill should retain the premises regulations provisions of the Pharmacy Order 2010, with some minor amendments meaning that premises will continue to be regulated by the General Pharmaceutical Council. This recommendation followed discussion about the use of 'Section 60' Orders (made under the Health Act) which the Law Commission thought should be repealed – apart from the parts applying to Northern Ireland and the regulation of pharmacy premises under the Medicines legislation.

The draft Bill – Regulation of Health and Social Care Professions Etc. Bill is available on the Law Commission's website. The Bill has not yet been presented to Parliament.

10. Changes to the Pharmacy Regulations

Regulations were laid on 4th March to amend the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 which came into effect on 1st April 2014.

Some of the changes are tidying up and providing consistency to wording. Of the remainder of the changes, particular noteworthy are:

- Regulation 18 (unforeseen benefits) is amended to clarify to Area Teams that only one of the three criteria of innovation, choice, and protected characteristics have to be satisfied.

- Regulation 24 (relocation) is amended so that when a distance selling pharmacy seeks to relocate, it is required to satisfy the same criteria as it would have to have satisfied for an original DSP application. This ensures that a DSP that has been granted, cannot then relocate so that it is on the same site or adjacent to a provider of medical services with a patient list. Associated with this, Regulation 64 (DSP Conditions) is amended to clarify that these apply whether the DSP pharmacy was opened under the 2013 or the 2012 or the 2005 Regulations. However, there is a transitional provision which disapplies Regulation 64(3)(c) for those that have opened prior to 1 April 2014 or have already been granted an application and subsequently relocate. This amendment was to correct an inadequacy in the regulations, and because it identified a loophole, publicity could not be given to the provision until the last minute, so that exploitation would not occur.
- Regulation 31 (same or adjacent premises) has been amended, to impose the restriction on all types of applications made under the 2013 regulations (e.g. to add relocations and changes of ownership) and there is a corresponding amendment to Schedule 2 so that where a best estimate application is made, the test for same or adjacent premises will be made when the premises are identified.
- Regulation 40 (5 year rule) is amended to prevent the action of a blocking application which is made with the intent that this will be refused and trigger a new 5 year block.
- In Schedule 4 the provisions requiring callers who have specified appliances to be signposted to NHS Direct where telephone care lines are used in the out of hours periods has been amended by removing the reference to NHS Direct – because it has been abolished.

The regulations are available at http://www.legislation.gov.uk/uksi/2014/417/contents/made.

11. Submission to the APPG for Primary Care and Public Health inquiry

The All Party Parliamentary Group for Primary Care and Public Health recently launched an inquiry into 'Winter Pressures on Health Services'. PSNC submitted written evidence to the inquiry which is set out at **Appendix SDS 06/05/14 (pages 31-37)**.

12. Community Pharmacy – helping with winter pressures

It has been agreed that PSNC will work with NHS England to review the content and use of the winter pressures documents and tools in order that refreshed versions, where appropriate, are available for use during the next winter period.

13. PSNC Evidence Awards

The Awards have been reviewed internally by the office and in the light of the transition year and the priority focus on independent living it has been decided not to hold them this year but to reconsider in future years. Past experience has shown that holding Awards for consecutive years leads to diminishing response by LPCs.

14. Recent PSNC Briefings relevant to service development and commissioning

A number of PSNC Briefings have recently been published on the website which are relevant to service development and local commissioning:

PSNC Briefing 013/14: NICE public health guidance – Needle and syringe programmes

NICE has issued new guidance on needle and syringe programmes (PH52), and the majority of the ten recommendations include actions by community pharmacy, as most of the current services are provided by pharmacies. The recommendations will be taken into account by local authorities when reviewing and commissioning local services and the Briefing summarises the guidance and recommended actions.

PSNC Briefing 012/14: NICE public health guidance – Contraceptive services with a focus on young people up to the age of 25

NICE has issued new guidance on contraceptive services (PH51), with a focus on young people up to the age of 25, which aims to assist in improving contraceptive services which in turn will reduce inequalities, unwanted conceptions and teenage pregnancies. This Briefing explains the twelve recommendations which range from needs assessment and commissioning to provision, confidentiality and tailored support to meet

the needs of those who are socially disadvantaged. Many of the recommendations include actions required by service providers such as community pharmacies.

PSNC Briefing 011/14: NHS England's Business plan 2014-15 to 2016-17

At the end of March 2014 NHS England published a refreshed business plan – Putting Patients First Business plan 2014-15 to 2016-17 – which describes the organisation's plans for the next two years. The business plan builds on Everyone Counts: Planning for Patients 2014/15 to 2018/19, NHS England's earlier planning guidance for the healthcare system, which was published in December 2013. The PSNC Briefing summarises the elements of the plan which are of most relevance to community pharmacy.

PSNC Briefing 010/14: Changes to the GMS contract in 2014/15 (update)

This briefing updates PSNC Briefing 107/13 which summarised the changes being introduced to the GMS contract in April 2014. This briefing incorporates extra information on the changes, following the publication of briefings on the changes to the contract by NHS Employers. It highlights those aspects of the changes that may have an impact on community pharmacies.

PSNC Briefing 009/14: NHS England's emerging findings from the general practice Call to Action

In March 2014 NHS England published a summary of the responses to the general practice CTA and its emerging findings. The report focuses on the central role NHS England wants general practice to play in wider systems of primary care, and it describes their ambition for greater collaboration with clinical commissioning groups (CCGs) in the commissioning of general practice services. This PSNC Briefing provides a summary of the key elements of the document.

PSNC Briefing 06/14: The Sustainable Development Strategy for the Health and Care System 2014-2020

At the end of January NHS England and Public Health England published Sustainable, Resilient, Healthy People & Places – A Sustainable Development Strategy for the NHS, Public Health and Social Care system. This PSNC Briefing summarises the key points in the strategy and highlights its relevance to community pharmacy.

PSNC Briefing 004/14: The House of Care model for managing long term conditions

The house of care model is a metaphor for a proactive co-ordinated system of care and support for people with long-term conditions. In recent months it has been frequently cited in documents published by health policy organisations and NHS England. This PSNC Briefing provides a short description of the concept to assist LPC members and pharmacy contractors with understanding it and to allow them to engage in any local discussions on the topic.

15. Any other business

Appendix SDS 02/05/14

2014 Work Plan for the Service Development Subcommittee

The 2014 work plan for the Service Development subcommittee covers all items agreed at the November 2013 planning meeting.

Key for RAG coding
Red – needs attention / not started / high risk
Amber – underway / in progress
Green – completed / no further attention

Target Plans	Target date	Comment / Update on progress	R/A/G

In 2014 PSNC will seek to:
• implement its Vision for community pharmacy by:
  ○ influencing the development of NHS England's plans for primary care, ensuring that they include a substantial and central role for community pharmacy (with LIS);
  ○ negotiating a framework for the development of the services within the CPCF with NHS England (with FunCon);
  ○ collaborating with LPCs and others to build the evidence base for existing and prospective community pharmacy services, including the value of the services to patients and commissioners (with LIS);
  ○ ensuring developments in technology support the effective provision of pharmacy services;
  ○ working to ensure that regulations and their administration support the effective provision of pharmacy services.
• develop stronger and productive relationships with NHS England and Public Health England (with FunCon and LIS)
• promote adoption of standardised service commissioning (with LIS);
• support LPCs to increase local commissioning of community pharmacy services (led by LIS).			

1) Submit a robust response to NHS England's Call to Action on community pharmacy and any other elements of their work to define future plans for primary care.	March	PSNC's response to the CTA was submitted in March. The key messages in the response have been summarised into a document which is being used to lobby parliamentarians and has been made available to LPCs for use at a local level.	Green
2) Use speaking or other opportunities at healthcare conferences, seminars and other events to promote the use of community pharmacy services.	Ongoing	Speaking opportunities are regularly sought in order to promote community pharmacy services to external audiences. Alastair Buxton has recently spoken to a BAPW member conference on community pharmacy service development and at a conference on urgent and emergency care.	Amber
3) Following the completion of NHS England's primary care	Commence	NHS England is aiming to publish its primary care framework in September. In a	Amber

framework development work, negotiate with NHS England a framework for the development of the services within the CPCF, in line with PSNC's Vision.	in June	recent discussion with NHS Employers it has been agreed that, subject to NHS England's agreement, exploratory discussions on the future development of the CPCF may be undertaken following the completion of the current round of negotiations.	
4) Work in partnership with Carers Trust to support the testing of carer identification and support in community pharmacies, in order to develop the evidence for community pharmacy services.	Commence in January	Carers Trust has been funded by DH to undertake a range of actions to improve the ability of primary care professionals to provide support for unpaid carers. This part of that work is intended to be a one year project to explore the development of a 'Carer Friendly Pharmacy' concept, involving LPCs and Carers' Centres working together, with an evaluation undertaken by the University of Leeds. A draft description of the project was set out in the January 2014 SDS papers for information. Expressions of interest in participating in the project have now been received from ten LPCs and two are participating in an initial phase to develop and test materials for use in the project. Carers Trust has now appointed a project manager for the project.	Amber
5) Develop and submit to NHS England the case for the national commissioning of a seasonal flu vaccination service from community pharmacies.	February	Preliminary work that will support a proposal to NHS England was undertaken (development of a new service specification, SLA and supporting paperwork) as part of work to support urgent and emergency care services during winter. PSNC organised an event for LPCs on flu vaccination in March to share learning from the previous season and to highlight the benefits of taking a standard approach to commissioning the service to NHS England and PHE (who both had officials in attendance).	Amber
6) Develop and submit to NHS England the case for the national commissioning of a minor ailment service from community pharmacies.	June	Preliminary work that will support a proposal to NHS England has been undertaken (development of a new service specification for a winter ailments service, SLA and supporting paperwork) as part of work to support urgent and emergency care services during winter.	Amber
7) Develop and submit to NHS England and Public Health England the case for the national commissioning of an EHC service from community pharmacies.	November	This activity was intended to allow PSNC to assess the willingness and ability of the two bodies to collaborate on national commissioning of public health services in the current commissioning environment, where local government is the lead commissioner. The concept of national commissioning of this service was recently discussed with the Director of Health and Wellbeing at PHE, who said it would not be a realistic proposition in the current commissioning landscape.	Amber

8) Identify external barriers to community pharmacy service commissioning and seek to develop strategies to address these blocks.	May	This issue will be discussed at the May meeting of the subcommittee and resources that may be developed to overcome barriers will be considered and referred to LIS.	Amber
9) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of asthma management, in order to develop the evidence for community pharmacy services. Initiate work on a pilot service with partners if a suitable site can be identified.	October	One area has already expressed interest in working with PSNC on this and the likelihood of support from pharma industry companies has also been indicated in exploratory conversations.	Amber
10) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of hypertension management, in order to develop the evidence for community pharmacy services. Initiate work on a pilot service with partners if a suitable site can be identified.	December	Support to develop this concept has come from the DDA and they have already indicated an interest in collaborating on testing the concept.	Amber
11) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of diabetes management, in order to develop the evidence for community pharmacy services.	December	Initial discussions have been undertaken with Devon LPC and a pharmaceutical company, as they may both be interested in collaborating with PSNC on this matter.	Amber
12) Consider the option of piloting the national use of a small number of STOPP or similar indicators within the dispensing service, as a way to build the evidence base for future commissioning by NHS England. Implement if the concept is agreed.	August	The CPF project provides some evidence of the benefit of the application of STOPP or similar indicators.	Red
13) Work with NHS England and other partners to support the wider adoption of the NHS repeat dispensing service.	May	Discussions on this element of the proposed funding and service development package from NHS England commenced with NHS Employers in late April. A verbal update on this work will be provided at the May 2014 SDS meeting.	Amber
14) Work with NHS England and other partners to support the wider use of community pharmacy medicines optimisation services post-discharge from hospital.	July	Discussions on this element of the proposed funding and service development package from NHS England commenced with NHS Employers in late April. A verbal update on this work will be provided at the May 2014 SDS meeting.	Amber
15) Work with the RPS and other partners to develop or locate a suitable assessment tool which can be used by pharmacy teams to assess the adherence support needs of	December	The outline plan for this project has been discussed with the RPS and other stakeholders that need to be involved have been identified.	Amber

patients.			
16) Confidential item, subject to agreement with NHS England.	February	The timing of this work will be dependent on NHS England and NHS Employers. Supporting contractors to implement the requirements will fall within the remit of LIS.	Amber
17) Confidential item, subject to agreement with NHS England.	February	As above.	Amber
18) Confidential item, subject to agreement with NHS England.	February	As above.	Amber
19) Confidential item, subject to agreement with NHS England.	February	As above.	Amber
20) Develop and consider proposals on how the sector can gather evidence to support service development. Implement any subsequently agreed plan.	May	This will be discussed at the May 2014 SDS meeting, as part of the agenda item on external blocks to commissioning services.	Amber
21) Review the support community pharmacy can provide to support people to live independently, and agree actions that PSNC can take to develop this area of service provision. This work will include a review of options for the provision of adherence support by community pharmacies, including appropriate use of MDS.	July	This discussion and review of options can consider the development of MUR-like services for housebound patients, the provision of appropriate adherence support and relevant recent service developments such as the falls reduction element of the CPF project and the Croydon domiciliary MUR service.	Red
22) Review the nationally agreed substance misuse template service specifications and seek agreement of Public Health England to endorse and promote the revised documents.	June		Red
23) Work with Public Health England to review the service requirements for pharmacy provided stop smoking services.	June	PSNC is a member of the working group on the issue formed by PHE. Barbara Parsons has attended the PHE Pharmacy Commissioning Workshop and work from the group will inform future action by the PHE Tobacco Policy Team. Barbara has developed referral pathways in and out of pharmacy for inclusion in proposed PHE guidance.	Amber
24) Develop a business case and supporting documents on Blood-borne virus testing and Hepatitis B vaccination for	March	This work will be carried out in collaboration with HIE/Pinnacle Health Partnership (PHP). A draft business case has been developed by PSNC for blood-	Amber

LPC use.		borne virus testing and is being finalised with data provided by PHP.	
25) Develop a business case and supporting documents on the NHS Health Check service for LPC use.	April	This work will be carried out in collaboration with HIE/Pinnacle Health Partnership. The literature review has been completed and the draft business case is in development.	Amber
26) Develop a business case and supporting documents on EHC and other sexual health services for LPC use.	May	This work will be carried out in collaboration with HIE/Pinnacle Health Partnership.	Red
27) Develop a business case and supporting documents on stop smoking services for LPC use.	June	This ongoing work will be carried out in collaboration with HIE/Pinnacle Health Partnership and is linked to the work being undertaken with PHE (see 23).	Red
28) Review all LPC websites and other sources of information on locally commissioned community pharmacy services to find content to populate the new PSNC services database.	March	The LPC website review has been completed, and information is filed and available. Population of the services database is ongoing and database developments are being finalised by the website developer JellyHaus.	Amber
29) Once the initial population of the PSNC services database is complete, create a report that details the services commissioned in each LPC area to support a regular review of the services data within the database and national level monitoring of local service commissioning.	May	The reporting fields have been agreed and preliminary discussions have taken place with JellyHaus. This work will be taken forward once the new service database developments have been finalised.	Amber
30) Work closely with NHS England and HSCIC to ensure patient choice is protected during the implementation of EPS Release 2.	Ongoing	Regular liaison with LPCs and ATs to support the resolution of local problems related to EPS R2 rollout and nomination. In ongoing discussions with the EPS team at HSCIC we are continuing to argue for patient choice to be at the centre of any policy developments.	Amber
31) Monitor the implementation of EPS closely to identify problems arising and support sharing of lessons learned to feed into discussions with DH, NHS England and HSCIC on ensuring the system works effectively for pharmacies.	Ongoing	The office is undertaking regular reactive liaison with contractors, LPCs and ATs to support the resolution of local problems related to EPS R2 rollout and nomination. Proactive discussions about the ongoing implementation of EPS are regularly undertaken with a group of contractors.	Amber
32) Work with DH to agree guidance to support minimising the risk of system failures occurring and their impact and ensure that there is recognition in the funding arrangements of changes in business risk.	Ongoing	Discussions are on-going on business continuity guidance and the funding linked to this. It is hoped that this will be resolved soon. The business continuity template has been agreed and is available on the PSNC website.	Amber
33) Work with NHS England to ensure that nomination	Ongoing	The office is undertaking regular reactive liaison with contractors, LPCs and ATs	Amber

complaints are dealt with in an appropriate way, and issuing supporting materials for LPCs and contractors regarding nomination.		to support the resolution of local problems related to EPS R2 rollout including nomination. A PSNC Briefing on nomination is due to be published shortly.	

Appendix SDS 03/05/14

Identifying external barriers to community pharmacy service commissioning

LPCs have identified through the PSNC/Pharmacy Voice surveys of the commissioning environment the following obstacles:

- Complicated contracting arrangements (76%);
- Service prices offered that are unacceptably low to contractors (65%);
- Complicated tender arrangements (59%);
- Commissioners not understanding what pharmacy can do (59%);
- Resistance from other healthcare professionals (53%);
- Lack of budget for services (47%);
- Commissioners refusing to engage with contractors and/or LPCs (47%); and
- Commissioners not having a clear strategy for local services and health (47%).

More information on the survey of LPCs can be found in the LIS agenda papers.

Complicated contracting and tender arrangements

The changes to the NHS structures from April 2013 has meant that instead of one commissioner, the Primary Care Trust, which was responsible for commissioning and monitoring of local community pharmacy services, there are now three and each uses a different vehicle for commissioning:

1. The NHS England Area Team, which can commission some services which it has national responsibility for, such as the seasonal flu vaccination programme. NHS England is the only organisation which can commission community pharmacy Enhanced services;
2. Local Authorities, which are responsible for commissioning public health services and social care. Local Authorities can commission contractors directly using a non-mandatory Public Health Services contract which can vary considerably across the country, or by commissioning one lead-provider organisation to provide the whole of a service, such as sexual health, which then subcontracts any relevant services such as EHC from pharmacies.
3. Clinical Commissioning Groups (CCGs), which are responsible for commissioning specific disease and medicine optimisation services, long term condition management, minor ailments, palliative care and waste, using the NHS Standard Contract.

Not only are there now multiple commissioners and commissioning routes, there are also changes to the procurement processes – there may be tender or pre-tender exercises and services may be offered widely on an 'any qualified provider' basis. The tender may only be offered online without any other notice so LPCs have to keep watch to ensure that bids are made for relevant services. Tenders have always been time consuming exercises to engage in and most service contracts are now larger documents than those that have been used in the past. Community pharmacies often report that completing tender documents is very challenging and likewise more complicated contracts also present a challenge to review, understand and ensure compliance with terms and conditions is possible.

The role of Commissioning Support Units, which varies from area to area also complicates the commissioning process.

Lack of budget for services and unacceptable service prices/resistance for other HCPs

The NHS is going through a tough economic climate – gone are the days of year on year increase in investment into the NHS. All commissioning organisations have a responsibility to look for the most

cost effective services that produce the required outcomes on limited budgets. This means that current services are now being reviewed and may be commissioned from different providers and feel levels may be reduced or numbers of service provisions may be capped. This provides both opportunities and threats for community pharmacy – for example some services typically commissioned through GPs may be provided through pharmacies, other local pharmacy services may be lost to new providers.

In some areas contractors are starting to suggest that it would be better to do two or three local services well and at an acceptable fee than the current practice of many contractors, of providing as many locally commissioned services as possible.

With an increasingly competitive market, each provider will endeavour to retain current services. The main resistance to pharmacy services has been from GPs, for example with flu vaccination services, where they see a threat to their previous monopoly of provision. However there are examples of where co-operative working has produced good results and these should be used as examples of good practice to try to break down barriers. Multidisciplinary training can also assist in this.

Commissioners not having a clear strategy

This has been a problem in some areas during the transition period – however all areas will have to produce a new Pharmaceutical Needs Assessment and Joint Strategic Needs Assessment which will determine future strategies so this should become clearer over the next 12 months. Any pharmacy bids/tenders for services should align themselves with local strategies and national outcomes frameworks.

Commissioners not knowing what pharmacy can do/lack of engagement with contractors/LPCs

Linked to the point above – it is essential that local areas know the potential of community pharmacy to enable inclusion in local strategies. There have been some approaches nationally – LGA resource for local authorities on community pharmacy services, PHE support for the use of pharmacies to provide public health services and LPCs have been working hard to make approaches to commissioners. From the results of the survey, NHS England Area Teams have the best record for engagement and maximising pharmacy's potential through local commissioning. There have been some comments about the negative attitude from GP led CCGs which could be included in other HCP resistance.

Regional variation/interpretation of rules and regulations

Whereas we would argue for national services, or at least national specifications and prices for local use, such as the winter pressures resources co-produced with NHS England, there has been a move to localism. However whereas London has agreed the commissioning of flu vaccination services, County Durham AT has refused to discuss the service, citing changes to procurement regulations which is probably a local misinterpretation of centrally issued guidance.

Lack of evidence for service development

In the case of innovative services there may be a lack of evidence base for community pharmacy service provision, but frequently evidence does exist, it is just not easily accessible by LPCs or contractors. This is particularly an issue, because evidence may be created by local service evaluations which LPCs are involved in, but LPCs do not necessarily see dissemination of this evidence as being part of their role.

PSNC resources that can be used to overcome barriers to commissioning

- PSNC guidance on the community pharmacy commissioning routes (on the PSNC website);

- PSNC guidance on the standard contracts to support LPCs and contractors;
- PSNC Briefings on the health and care landscape, which provide information to support discussions with commissioners;
- PSNC services database;
- PSNC business case templates;
- Template service specifications and associated resources;
- Literature reviews on public health services;
- General guidance on establishing contracting vehicles;
- Template LLP framework;
- List of providers of more specialist support on commissioning and contracting;
- LPC training events on relevant topics, e.g. negotiation skills;

PSNC's approach to gathering evidence to support service development

PSNC's services database has been at the heart of our approach to gathering evidence to support service development. Information on pharmacy services commissioned around the country and any service evaluations has been collated by the office for inclusion on the database. This information is then accessible to LPCs to use in local discussions with commissioners.

Some LPCs have been good at sharing information on local services, but some have not and therefore a more proactive approach is going to be used when the Pharmacy and NHS Policy Officer is appointed. LPCs will be contacted on a regular basis to find out about local service developments in order that relevant PSNC resources can be highlighted to the LPCs and timely information on service commissioning and evaluations can be obtained for inclusion on the database.

The information in the services database will also be mined in a more systematic manner to provide summaries of key information on current service commissioning. For example, evidence from service evaluations will be collated to provide papers which LPCs can use in discussions with service commissioners.

Examination of the available evidence will also allow gaps to be identified, so PSNC can seek opportunities to work with LPCs and other partners to fill those gaps via proof of concept studies for innovative service developments through to service evaluations and research on existing services.

Some LPCs are actively seeking funding from external sources to support service evaluations and the wider need for this activity to be undertaken was discussed at the 2013 LPC Conference. PSNC could in the future identify external funding opportunities to LPCs and, where required, provide some support to help LPCs apply for such funding (potentially working collaboratively with the other national pharmacy bodies).

Appendix SDS 05/05/14

Response to Improving Health & Patient Care through Community Pharmacy - a Call to Action

Introduction

This response to NHS England's Community Pharmacy Call to Action (CTA) (Improving Health and Patient Care through Community Pharmacy – a Call to Action) sets out PSNC's vision for the development of community pharmacy services and the NHS Community Pharmacy Contractual Framework (CPCF), detailing how that development would improve health outcomes for individuals and help the NHS to surmount the very significant challenges it faces as a result of population growth, an increase in long term conditions (LTC) and fiscal constraints.

Transformational change: Without transformational changes like those we outline, which will better harness the potential of community pharmacies to contribute to patient care and in doing so relieve burdens elsewhere in the NHS, we do not see how the health service will be able to survive the combined pressures of financial restrictions and increasing demand that it now faces.

Contractor engagement: PSNC is recognised by the Secretary of State for Health as being the representative of community pharmacies on NHS matters. The committee includes 31 independent community pharmacy contractors and representatives of multiple community pharmacy businesses, who between them represent all 11,500 community pharmacy contractors in England. As well as drawing on their insights and experience in writing this response, we held three regional events across England through which the committee sought the views of Local Pharmaceutical Committees (LPCs). LPCs have in turn arranged local events across the country for pharmacy contractors and their teams and in some areas for wider stakeholders, and we have attended a number of these. Engagement with pharmacy teams, who directly provide services to patients and the public every day, has allowed the views of a wide range of stakeholders to be considered.

Our response has also been informed by a range of evidence from local and national service evaluations collated over recent years, as well as a survey of pharmacy contractors which we used to assess their views on the development of community pharmacy services.

In the CTA document NHS England has posed four questions; we provide our answers to these questions below.

PSNC's vision for community pharmacy

Recognising the challenges the NHS faces and the need to significantly improve patient outcomes, in 2012 PSNC agreed a four-year strategy which is built around a clear vision for the community pharmacy service in 2016; this is detailed in Appendix 1.

The four service domains: Within PSNC's vision there are four key domains across which there is significant potential for community pharmacy teams to improve the lives of patients and the public:

1. Optimising the use of medicines;
2. Supporting people to live healthier lives / public health;
3. Supporting people to self-care; and

4. Supporting people to live independently.

The core Essential and Advanced services within the CPCF and locally commissioned community pharmacy services all fall within one or more of these domains and they contribute to improving the health of the population, but, as we will describe later in this response, community pharmacy has much more to offer to patients and healthcare commissioners.

A third pillar of care: If the community pharmacy service were to be further developed, building on the central medicine supply function across these four service domains, pharmacy could help the NHS to manage the financial constraints and increasing demands it faces by becoming the basis of a third pillar of care, supporting NHS service provision alongside the traditionally dominant pillars of GP-led care and secondary care.

In 2012 PSNC confirmed via a survey of community pharmacy contractors that this aspiration for community pharmacy service development is supported by the majority of the sector. In total 1,080 pharmacy contractors who between them owned or were responsible for 5,216 pharmacies responded to the survey, and 93% of responding pharmacy owners representing 98% of pharmacies agreed with this aspiration, with 45% representing 37% of pharmacies strongly agreeing.

Question 1 - How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy now and in the future?

Raising the public's awareness of the community pharmacy services available to them

In order for the public and healthcare commissioners to maximise the benefits they can receive from community pharmacy services, it is important that the public has a better understanding of the range of services available to them at their local community pharmacy and that they know it should be used as the first port of call for many healthcare needs.

Enabling consistent service delivery: One of the barriers to patients recognising and using the services provided by community pharmacies is the inconsistency in the range of services commissioned from and available at different pharmacies across the country. This can lead to patient confusion about the availability of services, which can deter them from seeking to use community pharmacy services. We recommend that this is tackled by NHS England commissioning a wider range of services as part of the national CPCF, in order that a consistent core of services is available from all community pharmacies. PSNC's initial suggested priorities for national commissioning would be a minor ailments service and a Flu vaccination service.

This winter NHS England promoted both of these services to local commissioners as a means of helping to manage the increasing demands on hospital and GP services. Both the services can have a significant impact on patient outcomes and they can enable more efficient use of healthcare resources by the NHS, for example by helping to prevent people visiting their general practice or hospital when they have a condition that could easily be treated with support from a community pharmacy, or by preventing hospital admissions caused by flu. Commissioning them nationally within the CPCF, so they are provided in a consistent manner from pharmacies across the country, would be the most effective way to enable community pharmacy to rapidly assist the NHS with tackling the challenges being experienced by urgent and emergency care services and GP practices. In Appendix 2 we describe in more detail how community pharmacy services can support the NHS to meet the challenges it is facing and improve patient outcomes.

Communications to develop patients' understanding: If these and other community pharmacy services are to be widely taken up by patients as part of an effective and truly integrated service provided by community pharmacy and other providers, there will be significant changes to the ways in which patients have traditionally received care. As a consequence of this there will be a need to develop patients' understanding of the choice of services they have to support the management of their long term conditions and other care needs. A communications campaign to develop patients' understanding of these changes would be required, particularly in the early days of implementing a new model of integrated care.

NHS England's recent investment in a promotional campaign to highlight to the public the availability of self-care advice from community pharmacies, alongside similar campaigns undertaken by national community pharmacy organisations, will help to raise the public's awareness of community pharmacy services. Additional promotional campaigns of this type are required on a continuous basis in order to achieve a change in the public's behaviour and their use of healthcare services.

Alongside such campaigns, if NHS leaders and politicians routinely spoke of pharmacists as part of the healthcare network ("pharmacists, doctors and nurses" rather than the oft heard "doctors and nurses") this would help to positively influence the public's perception of community pharmacy and the services it can offer.

Increasing referrals to community pharmacy

Increasing referral of patients to community pharmacies by other primary and secondary care professionals and NHS 111 services would not only assist in managing constrained workload capacity in GP practices and hospitals, but it would also help to re-educate patients about the range of services available at their local community pharmacy.

Referring patients who are being discharged from hospital to their community pharmacy for provision of an MUR provides one example of such a referral which is clearly in the interests of the patient and the NHS, but which currently does not occur routinely.

Referral incentives: Increasing the number of this type of referral requires incentives to be included in the relevant contracts for GP practices, hospitals and NHS 111 providers to encourage this behaviour. NHS England's Local Professional Networks (LPN) for pharmacy should also seek to support increases in the number of referrals to community pharmacies. In part this may be achieved by the agreement of formal referral pathways between the different providers, which can, where relevant, be incorporated into clinical systems such as NHS Pathways. Development of formal referral pathways will frequently require the application of local knowledge, but it should be possible for aspects of this work to be undertaken nationally in order to reduce local duplication of effort and to increase the speed of implementation. As an example, the national pharmacy bodies are currently working together with the team responsible for the development of NHS Pathways to identify opportunities for greater use of the pharmacy disposition within NHS Pathways algorithms.

Sharing of patient information: In order to support appropriate patient referrals being made to and from community pharmacies it is important that healthcare IT systems develop to allow the sharing of patient information between all healthcare providers. The inability of most community pharmacy teams and GP practices to communicate and share patient data electronically is proving to be a major block to developing new innovative services and effective collaborative relationships that would benefit patients.

There are two aspects to this information sharing and transfer. Firstly, direct electronic communication between community pharmacies and other healthcare providers must be facilitated, using standardised messaging systems which allow easy integration of the communications into patients' records. These systems may be used to share the results of patient tests relevant to pharmacy service provision, e.g. the INR of patients being dispensed warfarin. They may also be used to feed information and queries about prescriptions directly from the community pharmacy to the prescriber.

East Lancashire Hospitals NHS Trust has recently collaborated with partners to develop one such system (refertopharmacy system) to allow patients being discharged from hospital to be referred to their community pharmacy for support with their medicines post discharge.

The second aspect to information sharing and transfer is for community pharmacy to be able to access the Summary Care Record (SCR) and GP patient records, where there is a legitimate need for this access and the patient gives their consent. To support the development of a single consolidated record for information that could be used by all professionals actively involved in a patient's care, community pharmacy should be able to add content to the SCR and GP records, as well as being able to read them.

National leadership: The Secretary of State for Health has recently provided in principle support for appropriate community pharmacy access to records, but it is unclear how quickly this can be implemented. NHS policy on IT developments is increasingly to focus development at a local level, but PSNC is very concerned that achieving pharmacy access to GP patient records will not be possible without national leadership by NHS England. At the very least, there is a need for this leadership to drive the development and / or adoption of suitable interoperability standards, so that pharmacy and GP IT systems at a local level can all communicate with each other.

We therefore suggest that NHS England should put in place the infrastructure to let patients give community pharmacists access to their SCR and in due course their GP record, where the patient wishes this to happen. It is also likely to be necessary for contracts for all healthcare providers to include a requirement that they put in place systems to share patient information electronically across the NHS.

Community pharmacy's relationship with general practice

Community pharmacy and general practice have always worked closely together, linked by the flow of patients and prescriptions between the two professions, but relationships at a local level are not always as strong or productive as they might be and this can adversely impact on the ability of the two professions to collaborate to maximise health outcomes for patients.

Incentivising collaboration: Community pharmacy could work more closely with general practice, in order to support the work of GPs and their teams in improving the care of patients, in particular the management of patients with long term conditions. This could involve pharmacies taking on a greater role in caring for these patients and coordinating that care, via shared information and IT systems, more closely with that provided to the patient by their GP practice. NHS England has a role to play in enabling this by ensuring the alignment of the GP and community pharmacy contracts with the inclusion of clear incentives in both to drive collaborative working. In Appendix 2 we provide

illustrations of how community pharmacy medicines optimisation services could develop in a collaborative manner with GP practice provided care for patients.

Alignment of the contracts needs to happen at a time at which changes are being made to both the contracts; if, for example, changes are made to the GMS contract without consideration of how the CPCF could be aligned with those, then the opportunity to incentivise collaborative working between general practice and community pharmacies may be missed until the next contract review is undertaken. As an example, the development of a national community pharmacy minor ailments service, building on the widespread commissioning of this service at a local level, has always been blocked due to the inability of the Department of Health to avoid 'paying twice' for such a service (the GMS contract includes funding which would cover GP treatment of minor ailments). This has historically been a problem due to different policy teams within the Department of Health being responsible for the two primary care contracts, but NHS England, as a single commissioner of both contracts, should be able to coordinate its work to avoid missing opportunities to facilitate and incentivise better team working across primary care.

Joint local projects: NHS England's LPNs could play an important role in supporting effective liaison between community pharmacies, clinical commissioning groups (CCGs) and GP practices. This could include LPNs developing joint projects on issues of shared interest to GP and community pharmacy teams, as a means of creating better relationships between them, e.g. improving the flow of information about patients following discharge from hospital.

Supporting people to live healthier lives

It is important that all members of the primary care team ensure that they make every contact count when talking to patients. Community pharmacy is able to reach a significant cohort of people who do not regularly access their general practice, which presents an opportunity for more preventative interventions to be made to reduce people's risk of developing long term conditions. By helping patients to look after themselves more effectively and stay healthy, the burdens on general practice and all other health services could be reduced and significant cash savings, for example through prevented hospital admissions, could be made.

All community pharmacies are already providing healthy living advice to patients as part of the public health element of the CPCF and other services. For example, an evaluation of New Medicine Service (NMS) interventions recorded on the PharmOutcomes IT system in the first year of the service found that a total of 366,702 separate pieces of healthy living advice were given to the 224,554 patients who received the NMS. The majority of community pharmacies will also provide at least one locally commissioned public health service.

The Healthy Living Pharmacy (HLP) framework has provided a positive approach to focussing the pharmacy team on the promotion of healthy lifestyles and associated service delivery. The development of support staff skills and the increased motivation to provide these services seen has been a positive achievement of the HLP concept. Likewise the quality criteria used by HLPs has helped pharmacy teams to reflect on and improve the quality of the services they are providing. Learning from these and other aspects of the implementation of the HLP concept across the country may be able to inform the future development of the CPCF.

Maximising public health innovation and impact

We hope innovative services such as the Isle of Wight sexual health screening service for hepatitis, syphilis and HIV will continue to be developed by community pharmacy contractors, LPCs and innovative public health commissioners in response to specific local challenges. These local developments then provide inspiration and learning for commissioners to apply in other areas across the country and they can also inform the development of the CPCF.

Not all public health services are suitable for commissioning at a national level within the CPCF. However, for some services, such as supervised consumption of medicines for the treatment of substance misuse or provision of emergency hormonal contraception, there is sufficiently widespread need across all areas that it could be considered for commissioning from all community pharmacies, and we believe this approach would make sense. Currently there is unwarranted variability in the way in which many public health services are commissioned and specified. This leads to additional complexity and expense for commissioners and providers alike which in turn reduce the effort which can be focussed on successful provision of the services. We comment further on how this issue can be addressed in our response to question 2.

Question 2 - How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get more from their medicines?

National versus local commissioning

Most innovative community pharmacy services are first developed and commissioned at a local level as a result of providers and commissioners responding to a specific patient need within their locality. Once proof of concept and initial evaluation of a service has been undertaken, often at a local level, where there is a clear need for a new community pharmacy service in all areas, PSNC believes that it should be commissioned at a national level within the CPCF.

Dynamic services framework: The original vision for the CPCF, held by all negotiating parties, was for a 'dynamic framework' which, where appropriate, took local innovation and learning and used this to develop nationally commissioned services. Unfortunately this has not been realised since the implementation of the revised CPCF in 2005, but it is still the approach which PSNC and community pharmacy contractors believe should be used, through an ongoing active review and development process for the national elements of the CPCF. Utilising such an approach would support NHS England to adapt the community pharmacy offering to patients in a more active manner, responding to emerging healthcare priorities and NHS challenges.

National standards and services: PSNC believes that national commissioning of services and the application of a nationally agreed community pharmacy quality framework and, where needed, any additional accreditation requirements for individual services, brings a number of benefits to patients, commissioners and providers. The approach supports the rapid spread of innovation and widespread population coverage, so the maximum number of patients can benefit from provision of the service. As noted in our response to question 1, consistency of service provision across all pharmacies can help support a change in patient behaviour towards greater use of community pharmacy. As demonstrated by the introduction of the NMS, commissioning at a national level also allows the coordination of national and local support for service implementation and the efficient provision of education and development resources to community pharmacy teams. As a consequence, it allows a more cost effective and efficient rollout of services across the community pharmacy network compared to local commissioning of services.

Optimising local commissioning

Despite the benefits of a national approach, PSNC does recognise that it cannot be used for all service developments and that the local approach to service development must act as an incubator of innovation, which can then be spread further afield.

Local authorities and CCGs both have an important role in commissioning local community pharmacy services, but they will benefit from the support of NHS England Area Teams and their pharmacy LPNs, who can provide expert advice on commissioning services from community pharmacy. We believe

Area Teams and LPNs should support the strengthening of community pharmacy and local authority / CCG relationships in order that community pharmacy can effectively play its part in providing high quality services and delivering the best possible outcomes for patients and the local population.

Streamlining contracting to improve patient services: Where it is necessary to take a local approach to commissioning services, the current bureaucracy surrounding local contracting is proving to be a major barrier to commissioning of services from pharmacies and it is impeding the provision of services to patients. The current use of complex and unwieldy standard or locally developed contracts and tendering processes by commissioners for locally commissioned services, which may be of limited financial value, is seen on a regular basis. PSNC has already discussed with NHS England some of the challenges community pharmacies face with use of the NHS standard contract, but we believe further collaborative work on this topic would be beneficial. We are keen to work with NHS England and other interested parties to undertake a further review of the elements of the standard NHS contract which are applied to primary care providers in order to increase the chance of innovative local services being successfully commissioned by this route, to the benefit of patient care.

PSNC would also encourage NHS England to consider how it may facilitate easier local commissioning of services from community pharmacies via more extensive use of the less bureaucratic Enhanced services commissioning route where a CCG / local authority wishes NHS England to commission a service from community pharmacies on its behalf.

Standard service specifications: Another approach to simplifying the local contracting process for all parties is the use, wherever possible, of standard service specifications, service level agreements, service documentation, patient group directions, datasets and outcome measures. In the past, PSNC, the Department of Health and NHS Employers have collaborated to develop standard service specifications for commonly commissioned community pharmacy services. We understand that these documents were used extensively by Primary Care Trusts (PCTs) in order to avoid 'reinvention of the wheel' at a local level.

PSNC is keen to work with NHS England and other relevant stakeholders, such as Public Health England and local commissioners, to review the current suite of nationally agreed service specifications and where necessary to develop new specifications and associated documents, datasets and other tools to support local commissioning. This would build on successful collaboration in 2013 between PSNC, NHS England, LPCs and local commissioners which led to the development of a range of materials, including service specifications, service level agreements and documentation for use by pharmacies and with patients, for three services focussed on managing winter pressures (the documentation is available at psnc.org.uk/winter). Following the publication of these resources they were rapidly used by LPCs and local commissioners to commission and implement at least 14 new services in a very short space of time.

Supporting the quality of locally commissioned services

In the past, PCTs in the North West collaborated with community pharmacy organisations and the Centre for Pharmacy Postgraduate Education to develop and roll out a standardised approach to the assessment of pharmacists' competence to provide locally commissioned services.

Standardising accreditation: This approach has recently been developed, in collaboration with the Local Education and Training Board, to include Declaration of Competence frameworks for a number of locally commissioned services. This approach helps to make commissioning of community pharmacy services easier and brings greater consistency to the knowledge and skills required by pharmacy professionals providing services, which in turn should lead to a more consistent, higher quality service being provided to patients across different areas.

Alongside the suggestion made above to review and augment the current range of national service specifications and associated documents, PSNC is keen to work with NHS England and other relevant stakeholders to consider whether the Declaration of Competence framework approach, or something similar, could be used across England to support easier commissioning of community pharmacy services where an assessment of staff competence is necessary.

Supporting the shift of services into primary care

Over recent years health service commentators and leaders have highlighted the need for some money currently spent in secondary care trusts to be re-deployed to the commissioning of similar services closer to peoples' homes. This 'trickle-down effect' should support an increase in the number of services that can be commissioned from primary care providers such as community pharmacy and general practices.

An increase in provision of patient services in primary care has been an aim of numerous commissioners, including CCGs, however little progress has been made. One of the reasons for this is the lack of capacity in general practices to take on more workload from secondary care. PSNC believes that this challenge can be overcome by the transfer of some existing general practice workload to community pharmacy, freeing up capacity in general practices to allow the provision of new services previously provided by secondary care. We outline in detail some examples of how this might work in Appendix 2.

Extending the provision of clinical services

Community pharmacy's most important role must be helping patients, and consequently the NHS, to get the maximum value from prescribed medicines. This is at the heart of the medicines optimisation agenda and it allows community pharmacists to properly focus their core professional skills and knowledge on improving outcomes for patients.

To achieve this aim, the CPCF needs to support and incentivise community pharmacies to provide a wider range of medicines optimisation services. In Appendix 2 we describe in more detail possible options for the development of the CPCF to provide much more support for people to optimise the use of their medicines. For example, more support could be provided to patients within a specific cohort of diseases, such as people with asthma or COPD. We also illustrate how community pharmacy could take on some current general practice workload in a collaborative manner. For example this could involve the management of patients when they are first diagnosed with hypertension.

Clarifying pharmacy and GP roles: In order to support the implementation of such an approach to the collaborative management of LTCs, we believe that shared care protocols for the most common LTCs should be developed which clearly set out the roles and responsibilities of community pharmacy and general practice teams. Along with developments to ensure that GPs and pharmacies are working under contracts that incentivise them to work together to deliver the best possible patient care, as we have outlined above, this use of shared protocols will be a crucial step in the development of the community pharmacy service. We have seen in some areas GPs deliberately trying to block the commissioning of local pharmacy services, such as the provision of flu vaccinations to patients in the NHS target groups. While this territorialism is not surprising in the current financially squeezed environment, it does not lead to the best outcomes for patients and the NHS and we are keen for NHS England, given its new position commissioning services from both professions to consider how this can be addressed in the two national contracts, as we describe above.

Extending the provision of clinical services would necessitate much greater application of the community pharmacist workforce within community pharmacies towards provision of clinical services than is currently the place. However the supply of medicines should remain an integral part of the care provided by pharmacies to patients as this core function can provide key opportunities for pharmacies

to have contact with patients and to couple it with the provision of patient care. This will mean that pharmacy teams' skills must be developed to allow other members of the team to take on additional roles to support pharmacists as they work to expand the care being provided.

Incentivising care: As community pharmacists become more involved in making decisions on the treatment of patients' LTCs, the current community pharmacy funding mechanisms would need to be revised in order to remove the perceived incentives to supply medicines that are not needed by the patient. However, it is important that this only happens as part of the recognition and commissioning of care services provided by community pharmacists and their teams. This could include the development of a care fee based approach to commissioning integrated supply and care services, which would see community pharmacy funding incentivising the provision of high quality care to patients.

The community pharmacy network

The community pharmacy network provides very convenient access to healthcare services to most of the population of England, as highlighted by the Department of Health statistics quoted in the Call to Action Resource Pack. Following changes to the control of entry system, introduced by Government in 2005, there has been a significant growth in the number of community pharmacies with NHS contracts. This has led some to ask whether all community pharmacies are appropriately located to meet the needs of patients and the NHS, or whether there are now too many community pharmacies with NHS contracts.

Identifying service needs: PSNC does not believe that it is possible for NHS England to assess whether the current community pharmacy network is appropriate at present, as it first needs to identify the services that it wishes community pharmacies to provide in the future. It is only once NHS England's future commissioning intentions are determined for community pharmacy that an informed assessment of the appropriateness of the community pharmacy network may be made.

PSNC is also keen to have an open dialogue so that NHS England can understand the barriers its regulatory regime places on mergers and closures of community pharmacies, and how it can depress innovation. PSNC would wish these matters to be addressed in future reform of NHS regulations and policy.

Question 3 - How can we better integrate community pharmacy services into the patient care pathway?

Better integration of community pharmacy services with the wider healthcare system

We have described in the answers to questions 1 and 2 and in Appendix 2 how community pharmacy services could be developed to create better outcomes for patients, and how improved use of referrals and data sharing between all healthcare providers could support this. We have also described in our answer to question 1 the importance of enhancing the community pharmacy / GP practice relationship, potentially by joint working across the two professions on matters of common interest, such as improving the provision of care to patients that have recently been discharged from hospital.

Access to records: We reiterate the importance of improving the flow of data between healthcare providers and the need to provide community pharmacists with access to patients' Summary Care and GP records (with appropriate patient consent) to achieve better integration of services.

Integrating pharmacy into care pathways: Developing community pharmacy services across the four domains of PSNC's vision for community pharmacy (described in Appendix 1 and 2) would enable the NHS to achieve better integration of community pharmacy services into patient care pathways.

In particular, as the national commissioning of services within the CPCF allows the provision of a consistent range of services from all community pharmacies, this would in turn make it easier to include community pharmacy services in nationally or locally produced care pathways, as commissioners and other healthcare professionals could be confident that a specified service is available from all community pharmacies, making it easier for them to refer patients to receive a specific pharmacy service.

Identifying key services: We suggest that NHS England should work with PSNC to identify the disease areas or services where community pharmacy can best deliver outcomes for large numbers of patients in order to guide the agreement of early service development priorities.

Recognising the role of medicines in pathways: In addition to this, when patient care pathways are being developed at a local or national level, there should be a greater recognition of the role that medicines play in almost all care pathways. As a consequence, pharmacy should have a voice in the development of the vast majority of pathways, right from the start of the process.

Improving the use of data by community pharmacies

Community pharmacies were first to adopt the use of IT within primary care and its effective use continues to be integral to the provision of services. However, despite this the full range of functionality available in community pharmacy IT systems is frequently not used to best effect, and pharmacy contractors report that IT systems can be slow to adapt to their evolving requirements. In the past this may in part have been a feature of the restrictive top down approach to the development and rollout of IT specifications for NHS projects such as the Electronic Prescription Service (EPS). This saw the NHS setting out complex and detailed requirements for systems without significant engagement with either system users or developers. Learning from this experience of the National Programme for NHS IT (NPfIT), PSNC believes that although national leadership on IT is vital to drive development in the right direction, stakeholder engagement must be a key feature in any IT projects and the pharmacy and primary care IT market should have more freedom to respond to customer demands and to develop relevant functionality for those customers.

Data and service evaluation focus: The major step change in community pharmacy service provision we have already described in this response will require further development of pharmacy IT, so that systems facilitate efficient recording of information about patients and services provided to them. At the same time systems need to support the capture and interrogation of data to demonstrate the outcomes and effectiveness of commissioned services. Over the last few years community pharmacy has made significant progress in developing systems to capture and report on service data, but more progress could be made if agreement could be reached on standard datasets and outcome measures for commonly commissioned services. This approach has already been adopted for the nationally commissioned NMS and MUR services.

Making best use of the whole pharmacy team

Community pharmacy teams generally have a wide range of skills which are role based, but adaptable. As a consequence, if commissioners recognise what community pharmacy teams currently do and could do in the future, their value to improving patient outcomes, particularly in relation to promoting public health topics and supporting behaviour change, could be harnessed more effectively.

Certainty needed to support investment: Maximising the value of the community pharmacy team will require investment in developing the skills and capacity of that team. It may be that some of this investment can be provided directly by commissioners or Local Education and Training Boards, but where this is not possible, it is important that community pharmacy contractors have certainty on future commissioning intentions so they can confidently plan for and invest in the development of

their teams and facilities. In the past, certainty on commissioning intentions has been sadly lacking and this has negatively impacted on the willingness and ability of community pharmacy contractors to invest in such developments. The current fragmented approach to local commissioning does not support the development of such confidence to invest, which is another key reason why national commissioning of services could provide a better route for all.

Question 4 - How can the use of a range of technologies increase the safety of dispensing?

Enhancing the safety of dispensing

Community pharmacies currently provide a very safe dispensing service for the millions of prescriptions prescribed every year, but the sector must continuously strive to identify ways to further improve the safety of this and all other community pharmacy services.

PSNC recognises that there is a need for greater reporting of and learning from patient safety incidents across primary care, but greater clarity is required by community pharmacy teams on which patient safety incidents should be reported to the National Reporting and Learning System (NRLS) and we also suggest that NHS England needs to have realistic expectations, grounded on real evidence, of how many reportable patient safety incidents, i.e. those that meet the NRLS criteria, occur in community pharmacies.

Improving reporting functionality: NHS England needs to work collaboratively with community pharmacy stakeholders to improve the functionality of reporting via the current NRLS system or using a centralised approach to reporting in the case of larger community pharmacy companies. Feedback from community pharmacy contractors suggests that the current NRLS web-based system is very time consuming to use and this inevitably impacts on the willingness of busy pharmacy teams to take time away from the provision of services to patients to report incidents. An effective system will be one which allows rapid and simple reporting of those patient safety incidents which are most likely to bring valuable learning for the NHS and community pharmacy.

The Department of Health and stakeholders also need to make rapid progress in removing the criminal sanctions for dispensing errors which inevitably depress the willingness of pharmacy professionals to report dispensing errors to NRLS.

Better use of technology

We have already highlighted in the answers to the previous questions the importance of community pharmacy access to patients' SCR and GP records, where the patient consents to this, as a means of enhancing the medicines optimisation support that community pharmacies can provide. Access to these records could also support improved safety in the dispensing process, for example, allowing assessment of recent test results when dispensing high risk medicines, without the need to contact the GP practice. We reiterate our view that NHS England should put in place the infrastructure to let patients give community pharmacists access to their SCR and in due course their GP record, where the patient wishes this to happen. We also believe that it is necessary for contracts for all healthcare providers to include a requirement that they put in place systems to share patient information electronically.

Standardised bar coding approach: Some pharmacies have already adopted integrated robotic and IT systems to partially automate the dispensing process, but this approach is not currently a viable proposition for many community pharmacies. The use of original pack dispensing using barcode scanning technology as a part of the robotic dispensing process can improve the accuracy of dispensing, but the same accuracy checking software could also be implemented at much lower capital cost without the use of robotic technology. Adoption of this type of technology to assist in safe

dispensing of medicines may in some circumstances need the support of the NHS or Government intervention, for example, to ensure a standardised approach is taken by medicines manufacturers to labelling and bar coding of products.

PSNC was disappointed by the reduction in the scope of the NPfIT, when it moved from a broad programme aiming to support the expansion of primary care and harness community pharmacy's potential, to a modular approach, where the only element for community pharmacy has been the EPS.

Community pharmacy has however embraced other digital technologies to improve patient convenience and medication safety, for example online management of repeat prescriptions, the use of smartphone apps to alert patients when to take medication, or the use of text messages to communicate with patients. The sector has already demonstrated that it can use these technologies and it is willing to continue to do this in line with the rapid advancement of smartphone and mobile technologies.

IT market freedom needed: Learning from the previous experience of the NPfIT, PSNC believes it is important that the pharmacy and primary care IT market has freedom to develop relevant functionality for its customers. NHS England can support this approach by facilitating collaboration at a national level, for example by securing industry agreement on interoperability standards and the best way to implement them. In doing this, NHS England should again learn from the experience of NPfIT by ensuring there is wide stakeholder involvement throughout the process.

PSNC also suggests that NHS England should avoid imposing systems and solutions that are not yet evidenced, such as the much wider use of robotic dispensing technology.

Conclusion

England's community pharmacy teams already play a vital role in supporting the nation to remain healthy or manage disease when it develops. But there are many opportunities to enhance the already significant contribution to healthcare that community pharmacies make, maximising the benefits of the network of pharmacy locations across the country, near where people live, work and shop. Doing so will not only bring benefits for patients, commissioners and the health service as a whole, but we also believe it will be absolutely vital if the NHS is to have a sustainable future.

The pressures on the NHS are well documented and Ministers continue to make clear that in their view, the health service must make radical changes if it is to survive. A move to develop the community pharmacy service, so that pharmacies are empowered to help patients to get the most from their medicines; allowed to take responsibility for patients with long term conditions; incentivised to work collaboratively with other healthcare professionals towards the same patient outcomes for which everyone will be rewarded; and enabled to offer all patients advice on how best to lead healthy lifestyles and lead independent lives, could represent just such a radical change.

We have shown how these roles are supported by existing evidence for community pharmacy services and pilots, but the extended roles for pharmacy are also supported widely beyond the community pharmacy network. As examples of this, Diabetes UK in a statement prepared for the Call to Action states:

"Community pharmacies are easily accessible and better use can be made of them to support people with diabetes in the future - including pharmacies providing advice, medicine reviews and healthy living guidance to help people to better manage their medicines and their condition. Diabetes UK support such initiatives and would like to see them rolled out more widely to assess how pharmacies can best contribute to the integrated care pathway."

While Asthma UK similarly highlights the need for further community pharmacy involvement, stating:

"Over one fifth of people with asthma have told us they didn't get their inhaler technique checked in the last year, so it is clear that we need more advice and support to help people with asthma. Pharmacists can play a pivotal role here to educate patients, help them to understand how to get the best out of their medicines and to support them in using their self-management plans.

With the new commissioning environment in England, [community pharmacy] should play a greater, more central role in meeting the changing needs of people with asthma and becoming a key player together with other healthcare professionals. One important way is through implementing the NICE Quality Standards and we look forward to working closely with the profession to achieve this."

In this response we have outlined how the development of community pharmacy services across a number of important domains could help to improve patient outcomes and reduce pressures on other health services, and we have sought to find ways in which NHS England could achieve these changes. We have highlighted some of the obstacles to progress, such as resistance from other professionals and the complexity of commissioning arrangements, and we have detailed how NHS England could facilitate the greater contribution of pharmacy, by enhancing the range of national services commissioned via the CPCF, alongside greater local commissioning; by making pharmacies an integral part of all care pathways and granting them access to patient records; and by designing primary care contracts that ensure healthcare professionals are working together rather than competing with each other.

We hope that NHS England will be able to take many of these ideas forward, but we recognise that NHS England alone cannot be responsible for the radical changes we have proposed. Local government, Clinical Commissioning Groups and other local commissioners will have a role at a local level to facilitate the development of innovative practice and the fostering of better relationships between pharmacists and all other healthcare professionals. But equally community pharmacy itself needs to demonstrate the ability to provide services to a consistently high quality in order to enhance its relationships with GPs and commissioners.

Everyone has a part to play, and as such PSNC is very keen to continue a close dialogue with NHS England on how community pharmacy can develop its services to better support the care provided by general practice and to benefit both patients and the NHS.

Submission to the APPG for Primary Care and Public Health inquiry

Written evidence submitted to the 'Winter Pressures on Health Services' Inquiry of the All Party Parliamentary Group for Primary Care and Public Health

March 2014

PSNC is pleased to be able to submit written evidence to the Inquiry into Winter Pressures on Health Services being undertaken by the All Party Parliamentary Group for Primary Care and Public Health. We are happy to provide further information on any community pharmacy services that are described below or to further discuss community pharmacy's contribution to easing winter pressures with members of the Group.

Summary

- Community pharmacy services already play a significant role in supporting patients and the wider NHS during winter.
- Better use of existing community pharmacy services and national commissioning of services such as flu vaccination and a minor ailments service would allow community pharmacy to play an even greater role during winter.
- Community pharmacy medicines optimisation services can help people to manage their long term conditions more effectively and avoid being admitted to hospital.
- The accessibility and convenience of community pharmacy flu vaccination services is resulting in an increase in the number of people being vaccinated, particularly in the hard to reach under 65 years target group; national commissioning would result in an event greater impact.
- National commissioning of a minor ailments service would support the transfer of significant workload from general practice to community pharmacy, creating the capacity for GP teams to focus more time on managing the treatment of high priority patients.
- Local commissioning of standardised 'off the shelf' services allows rapid and efficient implementation of community pharmacy services.

Managing Winter Pressures with help from Community Pharmacy

Health services, particularly urgent and emergency care services, are under immense pressure at the moment due to the increasing demand fuelled by the ageing population and the rise in the number of people with long term conditions, combined with the need to make significant financial savings. In the winter months these and additional pressures caused by the effects of the weather on health and seasonal conditions can exacerbate these problems and often leave urgent and emergency care services struggling to cope. PSNC believes that a transformation of healthcare is required to address these and other challenges, and that this will only be successful if the role that community pharmacy can play in this agenda is maximised.

Community pharmacies can support the provision of care and in doing so reduce winter demands on GPs, NHS 111 and A&E in a number of ways.

For example, in December 2013 PSNC, NHS England, LPCs and local commissioners collaborated on the development of a range of materials to support the local commissioning of three services focussed on managing winter pressures – a winter ailments service, flu vaccination and an emergency supply service (the documentation and materials are available at psnc.org.uk/winter).

Following the publication of these resources they were used by LPCs and local commissioners to commission and implement at least 14 new services in a very short space of time. One of these was an emergency supply service commissioned from late January 2014 by the Shropshire and Staffordshire Area Team. Provisional data from the first six weeks of operation of the service shows there were 403 interactions with patients, over half of whom would have contacted the GP out of hours provider had the community pharmacy service not been available (patients were asked which service they would have contacted had they not used the community pharmacy service: 3.7% A&E; 10.7% GP; 52.1% OOH GP service; 13.6% Walk in Centre; 19.9% other).

PSNC believes that by providing these and other services across four key domains, community pharmacy has the potential to do a huge amount more to help patients and to reduce winter and other pressures on the health service. The four key domains are:

1. Optimising the use of medicines;
2. Supporting people to live healthier lives / public health;
3. Supporting people to self-care; and
4. Supporting people to live independently.

A third pillar of care: If the community pharmacy service were to be further developed, building on the central medicine supply function across these four service domains as we have outlined below, community pharmacy could help the NHS to manage the financial constraints and increasing demands it faces every winter by becoming the basis of a third pillar of care, supporting NHS service provision alongside the traditionally dominant pillars of GP-led care and secondary care.

Optimising the use of medicines

It is estimated that up to 50% of medicines prescribed to treat long term conditions are not taken as intended by the prescriber. This can mean that long term conditions are not managed optimally and seasonal conditions during winter can further aggravate the situation and patients' conditions. In the US it is estimated that 11-20% of hospital admissions (30% for the elderly), A&E visits and repeat GP visits may be due to non-adherence to medicines.

The NHS community pharmacy contractual framework (CPCF) includes two services to help patients to understand and use their medicines to ensure they are getting the maximum possible benefit from them – the Medicines Use Review (MUR) and the New Medicine Service (NMS).

Reducing pressure on other health services: Both services have been shown to help improve adherence to medicines in some patients, and this can have a knock on effect, reducing pressure on other health services. For example, one study on the Isle of Wight in 2010 examined the effects of using MUR style consultations to educate asthma patients regarding the use of their medicines and the adoption of correct inhaler technique. Through the analysis of hospital data on the island, it was seen that emergency admissions due to asthma fell by more than 50% over a three month period

with resultant bed occupation days falling by a similar percentage. Additionally the numbers of asthma related deaths reported over the same time period were seen to have fallen by 75%.

A follow on project across the South Central region demonstrated substantial and statistically significant improvements in the management of both asthma and COPD and a positive association between the introduction of the project and reductions in hospital emergency admissions.

MURs and NMS can also be used to support people recently discharged from hospital during the winter period, to reduce the risk that confusion with their medicines leads to re-admission to hospital.

Long term condition management: PSNC's Vision for community pharmacy (psnc.org.uk/vision) describes how the current medicines optimisation services within the CPCF could be developed to enable pharmacies to provide more support for patients with long term conditions, which could in turn help free up capacity in general practices enabling them to focus their efforts on high priority patients.

Other community pharmacy services focused on medicines optimisation which could be commissioned locally include:

- Provision of rescue packs for COPD and other at risk patients – to support rapid management of disease exacerbations
- Palliative care schemes – to ensure availability of specialist medicines in primary care needed during end of life care

Supporting people to live healthier lives / public health

The provision of healthy living advice already forms part of the CPCF, with community pharmacies participating in up to six public health campaigns each year. National campaign topics could be chosen by NHS England to help modify public behaviours that can increase pressure on urgent and emergency care services. Some of these could be particularly applicable during the winter, for example:

- 'Keep Warm, Keep Well' campaigns
- Uptake of flu vaccination for at-risk groups

Provision of Emergency Hormonal Contraception in pharmacies, either sold over the counter or supplied at NHS/local authority expense can also help avoid attendances at GP practices, out of hours and walk in centres and A&E.

Flu vaccination services: Perhaps the most significant public heath contribution that community pharmacies can make to keep people healthy during the winter period and to reduce pressure on GP and hospital services is administration of flu vaccines. Many Area Teams commissioned the service from community pharmacies this winter and impressive results are starting to emerge as local data is collated. For example, in London community pharmacies vaccinated around 70,000 people at NHS expense. They managed to target 55% of their vaccinations to the hard to reach target group of people under 65 years of age with long term conditions.

Data from NHS community pharmacy flu vaccination services commissioned in two other areas of the country shows first time vaccination rates of 18% and 23% for people in the under 65 years group, demonstrating how the pharmacy service is accessing at-risk people who have not previously chosen to be vaccinated by their GP practice.

Many community pharmacies have provided a private flu vaccination service for a number of years and a significant number of people are choosing to access vaccination via this route. Data analysis from 139 pharmacies providing a private flu vaccination service this winter has found that 11% of patient were over 65 years of age and hence were eligible for an NHS funded flu vaccination, however they decided to opt to pay for a pharmacy service for reasons of convenience.

Supporting people to self-care

Many people presenting at A&E or at GP practices could self-care with support from a community pharmacy:

- 8% of A&E visits involve consultations for minor ailments, costing the NHS £136 million annually[1]
- 18-20% of GP workload is accounted for by minor ailments which equates to 57 million consultations a year and a cost of £2bn[2]

The NHS community pharmacy contractual framework includes:

- Support for self-care - the provision of advice and support by pharmacy staff to enable people to self-care for minor illness. This may involve the sale of an over the counter (OTC) medicine
- Signposting - referring people to other healthcare professionals or care providers when support beyond what the pharmacy can provide is necessary

Managing minor and winter ailments services: Local Minor/Winter Ailments Services offered in community pharmacies have been shown to help reduce demand on other service providers. These services allow pharmacies to provide OTC medicines at NHS expense in order to manage minor illness, sometimes just focussed on winter ailments. In particular they help divert people away from GP practices where they would otherwise seek a GP consultation and prescription because they receive free prescriptions.

Provisional data from a Winter Ailments Service commissioned in January 2014 by the Shropshire and Staffordshire Area Team to reduce winter demand on other services shows that 86% of patients using the pharmacy service would have consulted their GP had the service not been available.

As well as considering what services to commission, it is important that local commissioners ensure that the local directory of services used by NHS 111 includes accurate details of pharmacy services to which callers could be referred to reduce the demand on other service providers.

Supporting people to live independently

Community pharmacies provide a range of services to help support people to live independently in their own homes, including home delivery of medicines to the housebound, support with re-ordering repeat medicines and reminder aids to support medicines use.

Other community pharmacy services which can be commissioned locally include falls assessment services – to reduce the risk of medicines related falls. These services involve a community pharmacist undertaking a structured review of the patient's medicines, seeking to identify and address the risk that certain medicines may increase the risk of a patient falling. The Community Pharmacy Future project recently reported a statistically significant reduction in medical and self-treated falls following the provision of a falls risk assessment by community pharmacists in Wigan.

[1] Bednall R, McRobbie D, Duncan J, Williams D. Identification of patients attending accident and emergency who may be suitable for treatment by a pharmacist. Fam Pract 2003; 20(1): 54–57

[2] PAGB. Making the case for the self care of minor ailments 2009

These reductions can of course help to reduce healthcare needs and pressure on other parts of the healthcare service.

Re-ablement services which involve community pharmacists undertaking home visits to support people with their medicines following discharge from hospital have the potential to support people to live independently and avoid another admission to hospital. One such service on the Isle of Wight has led to a 37% reduction in hospital readmissions for the most vulnerable group of patients, with an estimated 8850 bed days saved from 254 high risk patients, representing a saving of £1.88m.

Raising the public's awareness of the community pharmacy services available to them

In order for the public and healthcare commissioners to maximise the benefits they can receive from community pharmacy services, particularly during winter, it is important that the public has a better understanding of the range of services available to them at their local community pharmacy and that they know it should be used as the first port of call for many healthcare needs.

Enabling consistent service delivery: One of the barriers to patients recognising and using the services provided by community pharmacies is the inconsistency in the range of services commissioned from and available at different pharmacies across the country. This can lead to patient confusion about the availability of services, which can deter them from seeking to use community pharmacy services. We recommend that this is tackled by NHS England commissioning a wider range of services as part of the national CPCF, in order that a consistent core of services is available from all community pharmacies. PSNC's initial suggested priorities for national commissioning would be a minor ailments service and a Flu vaccination service. During the winter of 2013/14 NHS England promoted both of these services to local commissioners as a means of helping to manage the increasing demands on hospital and GP services.

Communications to develop patients' understanding: If the services described above and other community pharmacy services are to be widely taken up by patients as part of an effective and truly integrated service provided by community pharmacy and other providers, there will be significant changes to the ways in which patients have traditionally received care. As a consequence of this there will be a need to develop patients' understanding of the choice of services they have to support the management of their long term conditions and other care needs. A communications campaign to develop patients' understanding of these changes would be required, particularly in the early days of implementing a new model of integrated care.

NHS England's recent investment in a promotional campaign to highlight to the public the availability of self-care advice from community pharmacies, alongside similar campaigns undertaken by national community pharmacy organisations, will help to raise the public's awareness of community pharmacy services. Additional promotional campaigns of this type are required on a continuous basis in order to achieve a change in the public's behaviour and their use of healthcare services.

Alongside such campaigns, if NHS leaders and politicians routinely spoke of pharmacists as part of the healthcare network ("pharmacists, doctors and nurses" rather than the oft heard "doctors and nurses") this would help to positively influence the public's perception of community pharmacy and the services it can offer.

Increasing referrals to community pharmacy

Increasing referral of patients to community pharmacies by other primary and secondary care professionals and NHS 111 services would not only assist in managing constrained winter workload capacity in GP practices and hospitals, but it would also help to re-educate patients about the range of services available at their local community pharmacy.

Referring patients who are being discharged from hospital to their community pharmacy for provision of an MUR provides one example of such a referral which is clearly in the interests of the patient and the NHS, but which currently does not occur routinely.

Referral incentives: Increasing the number of this type of referral requires incentives to be included in the relevant contracts for GP practices, hospitals and NHS 111 providers to encourage this behaviour. In part this may be achieved by the agreement of formal referral pathways between the different providers, which can, where relevant, be incorporated into clinical systems such as NHS Pathways.

Sharing of patient information: In order to support appropriate patient referrals being made to and from community pharmacies it is important that healthcare IT systems develop to allow the sharing of patient information between all healthcare providers. The inability of most community pharmacy teams and GP practices to communicate and share patient data electronically is proving to be a major block to developing new innovative services and effective collaborative relationships that would benefit patients and the NHS.

There are two aspects to this information sharing and transfer. Firstly, direct electronic communication between community pharmacies and other healthcare providers must be facilitated, using standardised messaging systems which allow easy integration of the communications into patients' records. These systems may be used to share the results of patient tests relevant to pharmacy service provision.

The second aspect to information sharing and transfer is for community pharmacy to be able to access the Summary Care Record (SCR) and GP patient records, where there is a legitimate need for this access and the patient gives their consent. To support the development of a single consolidated record for information that could be used by all professionals actively involved in a patient's care, community pharmacy should be able to add content to the SCR and GP records, as well as being able to read them.

We therefore suggest that NHS England should put in place the infrastructure to let patients give community pharmacists access to their SCR and in due course their GP record, where the patient wishes this to happen. It is also likely to be necessary for contracts for all healthcare providers to include a requirement that they put in place systems to share patient information electronically across the NHS.

Optimising local commissioning

PSNC believes that national commissioning of services and the application of a nationally agreed community pharmacy quality framework and, where needed, any additional accreditation requirements for individual services, brings a number of benefits to patients, commissioners and providers. The approach supports the rapid spread of innovation and widespread population coverage, so the maximum number of patients can benefit from provision of the service. In practice this would mean that community pharmacies could have a far greater impact in helping patients and relieving winter and other pressures elsewhere in the health service.

Despite the benefits of a national approach, PSNC does recognise that it cannot be used for all service developments and that the local approach to service development must act as an incubator of innovation, which can then be spread further afield.

Streamlining contracting to improve patient services: Where it is necessary to take a local approach to commissioning services, whether to help winter pressures or to meet any other need, the current

bureaucracy surrounding local contracting is proving to be a major barrier and it is impeding the provision of services to patients. The current use of complex and unwieldy standard or locally developed contracts and tendering processes by commissioners for locally commissioned services, which may be of limited financial value, is seen on a regular basis. PSNC has already discussed with NHS England some of the challenges community pharmacies face with use of the NHS standard contract, but we believe further collaborative work on this topic would be beneficial. We are keen to work with NHS England and other interested parties to undertake a further review of the elements of the standard NHS contract which are applied to primary care providers in order to increase the chance of innovative local services being successfully commissioned by this route, to the benefit of patient care.

PSNC would also encourage NHS England to consider how it may facilitate easier local commissioning of services from community pharmacies via more extensive use of the less bureaucratic Enhanced services commissioning route where a CCG / local authority wishes NHS England to commission a service from community pharmacies on its behalf. Area Teams were permitted to take this approach to 'co-commissioning' of the three winter pressures services described above, which led to the rapid commissioning of some services by the Area Team, using CCG funds. Area Teams have however been advised that they should not take this approach to commissioning other services on behalf of CCGs or local authorities.

Standard service specifications: Another approach to simplifying the local contracting process for all parties is the use, wherever possible, of standard service specifications, service level agreements, service documentation, patient group directions, datasets and outcome measures. In the past, PSNC, the Department of Health and NHS Employers have collaborated to develop standard service specifications for commonly commissioned community pharmacy services. We understand that these documents were used extensively by Primary Care Trusts (PCTs) in order to avoid 'reinvention of the wheel' at a local level. A similar approach was taken with the three winter pressures services described above and we believe that NHS England should seek to replicate this approach across a wider range of community pharmacy services.